

DISEASES

Vol. V.

February, 1939

No. 2.

OF THE

CHEST

Official Organ of the Amer. College of Chest Physicians
Editorial offices 1018 Mills Building, El Paso, Texas
Business Address P. O. Box 1069, El Paso, Texas

MEMBER: ASSOCIATED EDITORS OF TUBERCULOSIS PUBLICATIONS



(A MONTHLY PUBLICATION)

Subscription: United States and
Canada \$2.00 per year. Other
countries \$2.50 per year.
Entered as second-class matter
August 18, 1936, at the post office
at El Paso, Texas, under the Act
of August 24, 1912.

Editorial Comment

ST. LOUIS The meetings of the American
BIDS YOU Medical Association are becom-
WELCOME ing more interesting each year.

The increased attendance at each succeeding meeting is sufficient evidence that these meetings hold considerable interest for the visiting physicians. The Scientific Exhibits and the Scientific Assemblies are beyond question the finest postgraduate courses which any physician can hope to obtain. A week or as many days as you can spare away from your office could not be spent more profitably.

The American College of Chest Physicians will hold its Fifth Annual Meeting at the Chase Hotel, St. Louis, on May 13-14, the two days preceding the meeting of the American Medical Association. An interesting Scientific Session is being arranged by the Scientific Program Committee of the College. Prominent speakers have been invited to address the assemblies. The Entertainment and General Arrangements Committees have prepared interesting entertainment features. We are looking forward to a large attendance at this meeting.

In order that you may obtain the kind of hotel reservations you desire, we urge that you communicate *now* with the manager of

the Chase Hotel and make your wants known to him. Desirable hotel accommodations for the meetings are taken up early, so if you are planning on attending the meeting, make your reservations *now*. It would be well for you to notify the Executive Secretary of the College when you have completed arrangements for hotel accommodations, giving him the name of the hotel where you have made your reservations. This will enable the office to keep you posted on arrangements for the meeting.

R. B. H., Jr.

VENDORS OF SHODDY

For twenty years State Medicine has been slowly, but quite thoroughly, taking over the control of treatment of tuberculosis in these United States. Many of us have viewed this transition with deep regret. We have suffered financial losses because of investments in private tuberculosis hospitals and we have lost remunerative positions on the staffs of these private hospitals. These changes, incident to State Medicine, commanded our attention because they were personal. Physicians soon recover from the sting of personal loss and as soon as a little perspective is gained our group realizes that the terrific loss is to communities that lose so many beds

dedicated to the treatment of tuberculosis—losses they can ill afford to sustain.

This socialized trend in the treatment of tuberculosis would not be regretted for long if its only influence was that it hit some of our pocketbooks. We view with alarm the socialization of the practice of tuberculosis because of its influences other than economic.

Socialization of tuberculosis practice in the United States is the same socialized medicine that we have always known. Fundamentally, it must be "the greatest good to the greatest number." Then is it a great asset to the state? Selective treatment of the individual case must always be sacrificed for the one and only thing that counts in socialized medicine—the state. Under its sinister influence such practices as ambulatory pneumothorax, refill stations on convenient street corners, and rushing patients to radical surgical procedures have become the vogue. Patients are told that they need not stop work but can continue at their vocations and with the convenient refill stations may have artificial pneumothorax while they wait—getting their pneumothorax before lunch and their shoes shined afterwards. We have all seen patients paraded on the stage behind footlights with their street clothes on and we were entertained by guesses as to which side of the chest had had a thoracoplasty. These practices are defended on the grounds that a great number soon show negative sputum and clearing of other symptoms. Of course, we do not get the reports of secondary breakdowns six months, two years, four years after this breath taking treatment.

In April of last year the writer attended a most interesting and instructive clinic in Bellevue Hospital, conducted by Dr. J. Burns Amberson. Dr. Amberson would have the history read and a slide of the chest roentgenogram thrown on the screen. Then the audience was asked to suggest treatment. Dr. Amberson knew his audience—they were the new, the "stream lined" tuberculosis specialists from the Atlantic Seaboard and every case shown received an avalanche of suggestions all the way from ambulatory pneumothorax to radical thoracoplasty. However, no "stream lined" specialist wanted to wait for a three months or three weeks period of observation. In each instance, after the bets were laid, Dr. Amberson would quietly but dramatically

show that conservative bed rest had effected a most phenomenal change in each and every case. The 1938 model specialist challenged Dr. Amberson, stating that months of time were necessary to effect the cures he showed, and that the patients at Bellevue might have that much time. He cited a patient of his own, the manager of a great industrial works, who had no time to devote to a long period of bed rest and demanded immediate and decisive treatment of his tuberculosis.

I wonder if the doctor with the great industrialist as a patient explained to that hard-headed business man that he was afflicted with a disease which killed 700,000 people last year. I thought of the great men in tuberculosis of the generation past, the greatest of all health disciplinarians that our profession has ever known. I wondered if the "stream lined" doctor had taken command of his patient's case and was gently but firmly dictating what the patient must and must not do if that patient was to expect the doctor to assume the responsibility of his grave disease. And, in a moment of discouragement, I wondered if that hard headed industrialist was not in command of the situation, with our doctor friend in the role of a "Vendor of Shoddy," fearful that he was not going to make a sale to a tough customer.

State Medicine is new in tuberculosis—it is older in insanity, but many analogies can be drawn. The state hospital for tuberculosis and the state hospital for the insane are two very wonderful institutions and perform a marvelous service—for the state. Both institutions isolate patients that are dangerous to society. *Psychiatrists*, their brother physicians and the laymen, know the great value of the insane asylum to the people and to the state. They also know that if the family has the means, the proper place to treat the individual case of mental disease is in the private institution where individual study and individualized treatment can be carried out intensively.

Perhaps, after chest men have had State Medicine as long as the psychiatrists have had it, the value of the practice of mass management of tuberculosis may receive its proper classification and we can again come to regard the case of tuberculosis as having some

individuality and being in need of carefully selected treatment and the proper regard for the pathological cycle of the tubercle may supplant the opportunism of today. O. E. E.

THE RIGHT FOOT

Pennsylvania's now Secretary of Health, Doctor John J. Shaw, "got off on the right foot." In his first public utterance after his appointment to the Health Secretaryship, he stated, "I intend to call upon the leaders in the medical profession and with their help I will devote all my time and experience so that the people of Pennsylvania may derive every health benefit possible. Too many people outside the medical profession have been trying to tell doctors how medicine should be run."

Under the vigorous leadership of Doctor Shaw the Pennsylvania Plan for Tuberculosis Control will undoubtedly reach new heights of accomplishment, to the end that the murderous sick-patient labor (ironically called exercise) so long actually tolerated in Pennsylvania's State Tuberculosis Sanatoria, though rejected in principle, will come to an abrupt termination. We believe, too, that Doctor Shaw can be counted upon to establish proper homes on the grounds of the State Tuberculosis Sanatoria for the Staff Doctors and their families, and establish a rising pay scale for them, so that the constant employment of inexperienced "Floaters," worthless to the Sanatorium, will be stopped. F. W. B.

THE COMMON COLD Notwithstanding the fact that in recent years more worthwhile discoveries have been made since the history of medicine began, the common cold is with us just as much today as ever.

During the past twenty-four months we have seen great strides develop in the conquering of many other diseases. Sulphanilamide has definitely taken its place in the treatment of many acute infections, and good results have been obtained by insulin shock in the treatment of the mentally ill. The true value of cevitamic acid has been fully demonstrated. Protamine insulin has proved to be the greatest advance in the treatment of diabetes since the discovery of insulin.

Since 1937, considerable progress has been

made in the treatment of pneumonia, with specific anti-pneumococcic serum. Also encouraging, are the results of the investigations with mendalic acid preparation in the treatment of urinary infections.

For the most part, the treatment of the common cold has consisted largely of attacking the invading organisms locally. After adrenalin was developed and later ephedrine, these vaso-constricting drugs, in a large measure, replaced antiseptics which were previously used in nose drops. Proprietary combinations of such vaso-constrictors have been widely used in coryza because of glowing advertisements concerning their merits. The question has been raised as to whether or not such drugs may cause some harm by inhibiting ciliary action and, by admitting air more freely, encourage the growth of the causative organisms.

On the theory that the so-called virus from the common cold required large amounts of oxygen for its existence, heavy oil sprays and nose drops containing various combinations have enjoyed popularity for a long time. The promiscuous use of paraffin oil sprays and nose drops, especially in young children, has resulted in many cases in what is now called lipoid pneumonia.

It must be admitted that bland oil mixtures relieve the discomfort, and, if care is exercised in not putting in too much, the danger of aspirating these oils into the lungs will be minimized. Relief has also been obtained by carefully executed nasal syringing with the use of isotonic solution. Here again, care should be exercised because of the danger of washing infectious material into the eustachian tubes.

In summing up the research literature on the case of the common cold, nothing has been added that is of great value in the treatment, and very little in the prevention. We all agree that the only effective way to abort a cold is by physical rest in bed. Unfortunately, the average individual considers that he does not have time to do this, so colds will continue to be the most widespread of all diseases. It is to be hoped that the research will go on and that eventually the common cold will be as nearly under control as some of our more dangerous infections.

C. M. H.

Bronchoscopic Aspects of Early Bronchiectasis

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DURING the past three decades peroral endoscopy has advanced from an occasional, spectacular method of foreign body extraction to a commonly employed diagnostic and therapeutic procedure. This is readily evinced by the fact that at present foreign body extraction comprises only 2 per cent of the cases in which bronchoscopy and esophagoscopy are performed¹. The universal interest and development of the procedure have been due undoubtedly to the obvious advantages of direct visualization of lesions of the esophagus and tracheobronchial tree. Whereas formerly in a number of diseases of these organs the probable diagnosis was based indirectly upon the clinical manifestations and roentgenographic characteristics, at present the diagnosis can frequently be established directly by peroral endoscopy. Thus, establishing a diagnosis, which previously was, at best, difficult and often made too late to permit the institution of adequate therapy, can now be done in an increasing number of cases at a stage sufficiently early to allow the most effective therapy. However, the value of bronchoscopy as a diagnostic procedure in these conditions is perhaps no greater than its efficacy as a therapeutic adjunct. The deserving preeminence of bronchoscopic aspiration and medication in chronic suppurative pulmonary lesions, atelectasis, bronchial ulceration and stenosis, and certain forms of tuberculosis is now generally recognized, and is readily illustrated by its conspicuous prominence in the recent literature of bronchiectasis²⁻⁵.

The term bronchiectasis, derived from the Greek word meaning "bronchial dilatation," refers to the clinical entity first described by Laennec⁶ in 1819. It is characterized by a chronic cough associated with a foul, purulent

expectoration. The exact incidence of this condition has not been accurately determined and in the past the impression has been left that its occurrence is relatively rare. However, within recent years those who have made a more thorough study of the disease are firmly convinced that it occurs far more frequently than is commonly supposed. Indeed, some observers have expressed the opinion that of the chronic pulmonary affections bronchiectasis ranks second in frequency to pulmonary tuberculosis, if not surpassing it⁷⁻⁹. Undoubtedly, many cases of non-tuberculous bronchiectasis are frequently labeled "pulmonary tuberculosis" and even treated as such.

Although the acquired type of bronchiectasis is commonly considered a disease of middle age, more extensive experience has shown that its insidious development frequently begins in early childhood. This has been definitely demonstrated statistically by Hedblom⁷, who found that in a series of 134 cases the onset of symptoms began before the fifteenth year of age in 43.2 per cent. This is further corroborated by the observations of Hutinel¹⁰, Wiese¹¹, Brauer¹², Thorpe¹³, Lemon¹⁴, Findlay and Graham¹⁵, Duken¹⁶, and others. The significance of this fact cannot be emphasized too strongly, because only by its recognition in this early formative stage can the progressive development of bronchiectasis be adequately controlled and possibly arrested.

Clinically, the condition varies considerably depending upon the type, duration and extent of the lesion, and the degree of infection. Even in the same individual there may be periodic remissions and exacerbations. Moreover, contrary to the characteristic textbook description, the expectoration of profuse fetid sputum occurs as a rule only in the more advanced cases. In fact, too, some patients representing the "dry bronchiectasis" of Bezancon¹⁷ have little or no sputum and others have a cough with only a slight amount of sputum usually present in association with

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an acute respiratory infection. Hemoptysis is frequently encountered, although seldom severe, and is manifested usually as a slight tingeing of the sputum with blood. Clubbing of the fingers occurs in the advanced cases. The patients frequently complain of slight lassitude, loss of energy, and rather vague, indefinite symptoms. The physical findings vary considerably and in early cases, during periods of remission, they may be entirely absent. However, one of the most characteristic features of the disease is its inevitable progression in the absence of therapeutic intervention. The symptoms of cough and expectoration gradually become more severe and over a period of months or years the recurrent paroxysmal attacks occur more frequently until the patient is daily coughing "mouthfuls" of foul, putrid sputum. He develops into a miserable chronic invalid—socially ostracized, and usually stamped as a consumptive. Too frequently he has been futilely treated with medicaments of all sorts until he is so weakened and discouraged that death would be a welcome relief. These are the well-known characteristics of the far-advanced stage, which obviously should never be permitted to develop.

The bewildering pathogenesis of bronchiectasis forms one of the most active research problems today. Whereas a detailed review of the causation is considered beyond the scope of this presentation, certain factors are of utmost etiologic significance, particularly as regards the bronchoscopic aspects of the early stage of the disease.

One of the fundamental pathogenic factors in the production of acquired bronchiectasis is mechanical; namely, bronchial obstruction. Numerous conditions may be responsible for the occurrence of such an obstruction. A study of a series of cases of bronchial obstruction demonstrates that it may result from an inflammatory bronchial stenosis associated with upper respiratory infections, from inspissated pus, from an intra—or extrabronchial tumor, from a stricture following tuberculous or other ulcerations, from the long sojourn of a foreign body, or from a kinked bronchus due to extrinsic pressure produced by tumors, empyema, etc.

It is difficult or impossible to discover the nature of the actual obstructing element in

each case of bronchiectasis in which a mechanical factor may be held to have a direct causal relationship. Occasionally, as in cases of overlooked foreign bodies present in the lung over long periods of time, the obstruction is dramatically demonstrated roentgenographically when the foreign body is found at the apex of a bronchiectatic triangle. However, a far more common type of bronchial obstruction appears to be an inflammatory bronchial stenosis associated with upper respiratory infections. Such stenoses are common in childhood and manifest themselves by repeated "attacks of pneumonia" which do not follow a course typical of true pneumonia. The child becomes acutely ill; dulness, bronchial breathing, and bronchophony are found over one lobe, usually the lower, but the heart shifts toward the involved side, demonstrating that the process is one of *atelectasis* rather than pneumonia. The symptoms subside as soon as the cough becomes productive of the obstructing secretions, and the temperature returns to normal within a few days. Thus, with these acute symptoms so closely simulating pneumonia, the element of bronchial obstruction may be overlooked.

Whereas the majority of these patients recover spontaneously, or possibly after the use of expectorants, some continue with a persistent cough and a low-grade fever. The continuation of these apparently insignificant manifestations is due to the persistence of the atelectasis, and the roentgenogram reveals a triangular density at the base of the lung. This, too, generally clears spontaneously after several weeks, but has a tendency to recur, remaining present for increasingly long periods of time after each attack of "pneumonia." In a correlation of these progressive clinical and roentgenographic manifestations with the correspondingly changing endoscopic characteristics, it has been definitely demonstrated that this is actually a pre-bronchiectatic stage^{18, 19}. Therefore, the clinical recognition of this stage is of decisive importance because unless successful re-aeration of the lung is obtained, retention of pus will eventually lead to destruction of the bronchial wall and fibrosis of the interstitial tissue. As a general rule, the time interval which exists between the actual onset of such an obstruction and the eventual well-established

bronchiectasis is so great that the importance of the pulmonary infections of childhood is overlooked. Such lesions occur with relative frequency in childhood, and major attention must be directed toward them in discussing the bronchoscopic aspects of early bronchiectasis.

Whereas most of these cases recover spontaneously or after the use of expectorants, some necessitate more extensive therapy. Postural drainage is of definite value, and should be used in conjunction with the other methods of therapy, but not as the sole method. If this type of drainage is inadequate, endobronchial drainage should be instituted. The bronchoscopic picture of the disease during this stage demonstrates the need of active bronchial dilatation and frequent aspiration of obstructing secretions by means of a strong suction pump.

The bronchoscopic picture in this pre-bronchiectatic stage is of extreme interest. The entire tracheobronchial tree usually is found to contain a considerable quantity of rather tenacious muco-pus, which upon aspiration reveals an underlying mucosa somewhat thickened and reddened. However, the most significant finding is an area of intense inflammation around the orifice of a branch bronchus sufficient to produce occlusion. Occasionally, as the patient coughs, thick pus is seen to ooze through the stenotic orifice. The failure of this secretion to bubble out of the bronchus is definite evidence that the lung tissues beyond is airless. By shrinking the mucous membrane around this inflamed orifice with cocaine, by dilating it with forceps, and then by passing an aspirator directly into it, the thick, obstructing pus can be readily released. Prompt relief of symptoms and disappearance of the atelectasis characteristically follow bronchoscopic aspiration, if performed early in these cases.

In the cases of atelectasis of longer duration, an attempt should be made bronchoscopically to open the airway and permit better drainage of pus. In our experience it has been observed that, after repeated bronchoscopic aspiration, re-aeration may be accomplished in some cases. Frequent re-examination is necessary, however, to be certain that the atelectasis does not recur following subsequent upper respiratory infections.

In the more advanced cases, with characteristic roentgenographic triangular atelectatic areas which have been present for more than a year, there are definite bronchiectatic cavities with marked lung destruction and bronchial dilatation. Bronchoscopic aspiration is of palliative benefit to these patients and reduces the inflammatory reaction, but cannot produce return of normal function. However, such cases no longer have a hopeless prognosis. Because of the recent advances in thoracic surgery, lobectomy can be performed with reasonable safety to remove the diseased portion of the lung.

In conclusion, it may be stated that the bronchoscopic aspects of early bronchiectasis may be divided into a diagnostic, a prophylactic, and a therapeutic phase. Diagnostically, the bronchoscope aids in establishing the early differential diagnosis of a bronchial obstruction and the identity of the secondary invading organisms. Prophylactically, the early recognition and removal of foreign bodies, the dilatation of bronchial stenoses, the bronchoscopic aspiration of areas of pulmonary suppuration and suppurative bronchitis are invaluable in preventing the development of this disease. The active treatment should be directed toward establishing and maintaining adequate bronchial drainage. Whereas this can be done by postural drainage in some cases, in others the evacuation of secretions can be accomplished far more satisfactorily by bronchoscopic aspiration. In the advanced case, this is particularly indicated as a palliative procedure and as a valuable means of preparing the patient for surgical intervention. Finally, vaccines prepared from bronchoscopically-obtained secretions are found to be of considerable benefit in some cases.

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Should Non-Tuberculous Lung Diseases be Treated in the Tuberculosis Sanatorium?

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THE TITLE of this paper is a natural question, but at the outset one question calls for another. What are the nature and function of tuberculosis sanatoria today? Until recently, these institutions were prepared to give little more than domiciliary care as resthavens, principally for incurables, and the factor of isolation largely justified their existence. Oft-times meagerly equipped, they were the keystone of the arch of accomplishment in the campaign against tuberculosis through the years. Now the newer methods of diagnosis and treatment, particularly such surgical measures as pneumothorax, phrenic exeresis and thoracoplasty, require resources and equipment beyond the reach of some of these domiciliary institutions. On others, the idea of the modern hospital has been superimposed, and there has emerged the tuberculosis hospital, a teaching, therapeutic and prophylactic institution. Stewart¹ observed that its range in diagnosis may be fairly considered to cover both tuberculous and non-tuberculous diseases of the respiratory tract and that in treatment its range takes in a good many non-tuberculous pulmonary conditions as well as the whole of tuberculosis.

The efficacy of such an institution inheres primarily in the competency of its attending and consulting staff. Naturally, the physi-

cian interested especially in the pathology of the chest is chiefly concerned with pulmonary tuberculosis. Expert in this field as he is, the tuberculosis specialist is more apt to detect and be interested in other forms of disease of the lungs than other diagnosticians. Who is more competent than he to make a clinical diagnosis of pulmonary disease? Who, indeed, would not prefer his interpretation of a roentgen study of the lungs to that of the average roentgenologist? Both in tuberculosis and in non-tuberculous disease of the lungs treatment is predicated on early diagnosis. That pulmonary disease is incorrectly diagnosed or remains undiagnosed in numbers of cases until it has progressed to an intermediate or an advanced stage suggests the value of maximum utilization of the superior diagnostic skill of the tuberculosis specialist in early cases.

The tuberculosis hospital serves as a clearing house, not only for tuberculosis, but for all other diseases simulating it in symptoms or roentgenologic findings. Between 1931 and 1936 from 3,100 to 3,600 patients were admitted each year to the tuberculosis service of Bellevue Hospital in New York; of this number from 15 to 20 per cent were found not to be tuberculous². Thus, the importance of differential diagnosis in diseases of the

lungs is not to be underestimated.

Pulmonary malignancy is frequently diagnosed as tuberculosis. Bronchiectasis is relatively common, far more so than is ordinarily believed, and it is more frequently mistaken for tuberculosis than for any other condition. As a sequel to some recent acute illness, a pulmonary abscess may occur, requiring treatment of relatively brief duration, but a small chronic abscess is not so easily distinguished. Loculated empyema, essentially the same as a pulmonary abscess except for location, frequently ruptures into the lung following an acute illness and also is of short duration. Gangrene of the lung, occurring under much the same conditions as a pulmonary abscess, is not to be confused with bronchiectasis although it may be the terminal event of that disease. Syphilis and infections caused by fungi are also among the diseases to be considered in the differential diagnosis of diseases of the lungs. Pneumonoconiosis may readily be confused with tuberculosis and other diseased conditions of the lungs; silicosis, in particular, simulates tuberculosis.

Granted that a correct diagnosis is made, would the patient with non-tuberculous pulmonary disease elect to go to a tuberculosis sanatorium or hospital for the shorter or longer period of treatment that the case might require? Probably not. Phthisiophobia has by no means subsided among the laity. Why enter an institution designed to care primarily for patients with an infectious disease, a place whose stamp of tuberculosis is, in the public mind, upon every patient, whatever his disease? In many instances such a patient might have to travel a considerable distance, perhaps at great inconvenience and expense, to enter such an institution, only to be separated from family and friends and family physician and to be segregated from the other patients, although himself not the victim of an infectious disease. True enough, the services of the tuberculosis specialist are highly desirable in the management as well as the diagnosis of non-tuberculous disease of the lungs. True enough, also, the incidence of infection from tubercle bacilli among the staff and other personnel of tuberculosis sanatoria and hospitals, where the danger is obvious and, therefore, constantly guarded against, is lower than in general hospitals.

But is not there likely to be a greater hazard to the patient with disease, of whatever nature other than tuberculosis, already established in the lung? The degree of danger is of course problematical, but silicosis offers a flagrant example of its possibilities.

It is well known that this modern industrial octopus, known to Hippocrates and the ancients as "the disease of stone cutters," predisposes to tuberculosis, and not infrequently the first symptoms are those of a superimplanted tuberculosis. Seventy-five per cent of sufferers from silicosis die of tuberculosis; the tuberculosis may appear at any stage in the progress of the silicosis; a quiescent tuberculosis may be reactivated by exposure to silica; and, the more extensive the silicosis when the tuberculosis first manifests itself, the more rapidly the tuberculosis progresses and the sooner a fatal termination eventuates. In view of these facts, as recently set forth by Behneman³, it would seem the better part of wisdom to keep patients suffering with silicosis as widely separated from tuberculous patients as possible, even though the treatment is the treatment of tuberculosis. Observing that no other group is so susceptible to tuberculosis, Head and Rosenblum⁴ concluded that a patient with silicosis uncomplicated by tuberculosis should not be allowed in a tuberculosis hospital, much less confined there.

Where, then, may the sufferer from silicosis or bronchiectasis or other non-tuberculous disease of the lungs turn to avoid the disadvantages and at the same time avail himself of the advantages offered in a sanatorium or tuberculosis hospital? A few years ago it was suggested that the great task of the day was to save the tuberculosis sanatoria from themselves by salvaging all that was good in them and producing from it the tuberculosis hospital. Today, there appears to have devolved upon the general hospital the responsibility of including within its precincts the modern sanatorium or tuberculosis hospital, or at least of supplementing the work of such a hospital or nearby sanatorium through close cooperation. The advent of surgery in the treatment of pulmonary tuberculosis has done much to promote this cooperative endeavor, which affords opportunity for the closest cooperation between the surgeon

and the tuberculosis specialist. This current trend has for its basis many advantages, mutually beneficial to the two types of institutions, advantages that redound to the good of tuberculous patients and to those with non-tuberculous pulmonary disease as well.

There is no more reason for the general hospital to exclude patients with tuberculosis than those with typhoid fever or pneumonia. With the patients properly segregated, and the nursing technic that used for acute infectious diseases, there is greater protection both to personnel and to patients than in a general hospital that has no tuberculosis service. Patients are often admitted to such institutions with diseases concurrent with undetected pulmonary tuberculosis or with undiagnosed pulmonary tuberculosis simulating other diseases. Unaware of its presence, their physicians intent on treating the more obvious disorders, these patients are received on the general medical service where the technic of tuberculosis prophylaxis is neither imposed nor observed, and they become a menace both to the personnel of the hospital and to the patients. That the danger is real is shown by the greater frequency with which nurses, medical students and interns contract tuberculosis in general hospitals than in sanatoria. In the best general hospitals with a tuberculosis division, methods of protection are properly understood and carried out, thus reducing the incidence of infection. Observation over a five-year period of the system of case finding and control used in the Bellevue Hospital School of Nursing caused Amberson and Riggins² to conclude that the seriousness of tuberculosis as a disabling and fatal disease among the nurses of this school does not appear to exceed that expected among young women in other occupations in New York City.

A study of the incidence of tuberculosis in general hospitals in Wisconsin, comprising two surveys by Pleyte and Holand⁵, revealed that from 18 to 24 per cent of the total deaths in these institutions were attributed to tuberculosis. Since all general hospitals, because of mistaken diagnosis or emergencies, admit tuberculous patients, whether they will or not, those that do so knowingly and willingly render particularly valuable service through the maintenance of a qualified tu-

berculosis service. Not only is the staff of such a service skilled in the diagnosis and treatment of tuberculosis, but adept as well in differential diagnosis. Numerous diseases, including influenza, typhoid fever, malaria, pneumonia, contagious diseases such as whooping cough and measles, bronchitis, pleurisy, and especially bronchiectasis, silicosis, fungous infections and other non-tuberculous pulmonary diseases may be mistaken for tuberculosis or have complications tuberculous in character. The broad opportunity for consultation with the staffs of other services in a general hospital expedites the handling of borderline cases and cases in which the patient with pulmonary disease suffers from complications or associated disease. Such diagnostic service makes possible the elimination of many cases of mistaken diagnosis, allows for the necessary and immediate treatment of the newly diagnosed condition, often avoids the labeling of a patient prematurely as tuberculous and prevents the stigma of residence in a sanatorium. It is estimated that approximately 12 per cent of all patients entering sanatoria do so with a mistaken diagnosis.

The general hospital with its staff and equipment available to care for every abnormal condition that might arise is obviously, then, exceptionally well equipped to meet adequately the needs of the tuberculous patient. Two decades or more ago, the American Medical Association, the American Hospital Association and the National Tuberculosis Association concurred in the opinion that the general hospital ought to be, and is, by right, the place for the tuberculous patient. In most of the hospitals in which temporary or permanent care of tuberculous patients has been undertaken, the results have been uniformly successful, the mutual benefits derived by all services proving more than compensatory. Thus, the practicability of a special department for tuberculosis in the general hospital has been fully established, not only by authoritative opinion, but also by practical experience.

If, then, the general hospital with a full tuberculosis service or a temporary service with close cooperation with a nearby sanatorium has so many advantages to offer the tuberculous patient, why is it not the ideal

place for the patient with non-tuberculous pulmonary disease? This patient, too, needs the skilled diagnostic aid of the staff of its tuberculosis service, its surgical facilities mayhap, its facilities for treatment, the advantages of its numerous services in case of complications or concurrent disease, its laboratory and bronchoscopic facilities and equipment for emergency measures. In addition, there is a maximum degree of protection from infection with tubercle bacilli and there is no stigma of residence in a sanatorium. Here the patient with non-tuberculous disease of the lungs has all the advantages of a sanatorium or tuberculosis hospital without its disadvantages. Also, there are available many other facilities in the event that they are needed.

It is to be regretted that the ideal in service is not always at the disposal of the patient with pulmonary tuberculosis nor the per-

son with non-tuberculous disease of the lungs. Perhaps, after all, among patients having non-tuberculous pulmonary disease he is most fortunate who is attended by the physician highly proficient in the diagnosis and management of diseases of the lungs, wherever he may be found.

Citizens Bank Building.

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Prevention of Tuberculosis*

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THE prevention of tuberculosis rests upon a tripod:

One: Diagnosis—cases must first of all be found.

Two: Segregation of cases when diagnosed.

Three: The finding, examining and safeguarding of contacts—those that have been in close association with a victim of the disease.

Let us deal briefly with diagnosis.

The late Dr. Lawrason Brown, of Saranac Lake, New York, said that one of the chief reasons for not diagnosing tuberculosis lay in not bearing the disease in mind. This aphorism was addressed primarily to physicians and there is no question as to its truth. In this year 1938 the laity is more health conscious than it ever has been, as is shown by the patient entering the doctor's office with sputum and urine specimens for examination, and requesting a blood count, a blood-pressure estimation, a basal metabolic rate,

an electrocardiogram, and what not. If the laity have thus become health conscious and, to a certain extent, laboratory conscious, they should also be aware of certain symptoms that herald the onset of one of the most serious and common diseases of the human race—pulmonary tuberculosis. Many of these symptoms, moreover, do not require the assistance of a physician in their determination, nor is there any question of the so-called "human equation"; they are open and shut propositions, speak for themselves, and can be appreciated by any person, as well as by the most experienced doctor. So many individuals put off seeing a physician because of economic reasons, lack of faith, belief that nothing is fundamentally wrong, fear of bad news, or some other reason, that it is well people as a whole should be conversant with some of the early evidences of failing health as far as tuberculosis is concerned. Well, what are some of these symptoms?

Fatigue

The patient notices this, complains of it, and only too often ascribes it to anything but the actual cause. The patient is tired and he knows it.

* Broadcast Station W.K.Y., Oklahoma City, Oklahoma, Meeting of The Southern Tuberculosis Association, November 16, 1938.

Loss of Weight

The grocery or the drug store scales tell the story. No need to seek a doctor's office.

Fever

A feeling of heat or flushing and some general aching, occurring especially after 4 p. m., should cause the individual to take his temperature. Knowledge of how to use and read a clinical thermometer in this day and time should be universal, though one is often astounded at the appalling ignorance of those who should know better. The readings of the thermometer are independent of any doctor or clinic. Any daily temperature over 99° should cause concern.

Cough

A symptom which is self-evident and which proves itself "without benefit of doctor." Any cough lasting more than two weeks should be investigated. Beware of "cigarette coughs"—they usually constitute an escape from reality.

Sputum or Expectoration

This cannot be concealed and is always disagreeable, if not revolting, to the individual. Sputum persisting for a fortnight demands attention. Examination at competent hands for the germs of tuberculosis or for other germs that may be, and often are, present can be secured free of charge at any state or City Board of Health Laboratory. All that is needed is a wide-mouthed bottle (one ounce size), a bit of sputum (thick) the size of a nickel, a five-cent stamp and an address—yet how often do we still see patients with advanced tuberculosis who have been under the care of practitioners and whose sputum has never been examined!

Why am I dwelling on these simple and almost axiomatic facts? Why emphasize the obvious? It is because in speaking to a lay audience, I am anxious to stress the factors involved in suspecting tuberculosis which can be ascertained without consulting a physician; because while people are now generally "health conscious," they still remain pitifully "disease unconscious"; and, therefore, they should be instructed as to what they themselves can do, so that the ravages of an insidious disease will not gain unwarranted head-

way. Also, bear in mind that all I have suggested costs not one penny—save perhaps a dollar and a quarter for the clinical thermometer.

Given the co-existence of two or three of the above-mentioned symptoms, the individual should consult a competent physician or clinic. With the evidence presented by the patient, further investigations will then be made, such as physical examination, x-ray, etc., with which we have no concern in this talk.

The diagnosis of tuberculosis having been definitely established, isolation of the patient is essential if the germs of tuberculosis are present in his sputum, for then there is definite danger to those with whom he associates; and the danger is in direct proportion to the youth of the contacts. In the higher economic brackets, a private room and bath with separate dishes, towels, etc., and with exclusion of young children from the invalid's apartment will suffice for adequate protection. But how few stricken with tuberculosis can supply such a set-up! Failing this, immediate removal to a hospital or sanatorium is most desirable; but if this be wholly impracticable, as much segregation as is possible under the given set of circumstances should be carried out until such time as entrance into an institution becomes feasible.

The prevention of tuberculosis, however, is not at an end when the actual case has been discovered. It has but just begun. In the vast majority of instances, the patient ill with tuberculosis has been in contact with a variably large family and with fellow workers in the office, whose employer should be notified. These individuals who have been exposed and who are known as "contacts" must be investigated in order to see whether they, too, have developed the disease. Fortunately, we have at our disposal a simple, painless and very accurate diagnostic measure—the skin tuberculin test—which can be given by any competent physician, and which, contrary to the opinion of many parents, is free from risk or danger to children. An individual who has been infected with tubercle bacilli, even though he may not be sick with the disease, will react positively to the test; in other words, inside of forty-eight hours there will appear about the site of the little hypodermic

injection, a red area varying in diameter from that of a dime to that of a silver dollar. The appearance of a positive reaction does not mean that the individual has active tuberculosis (except in children under two years of age), but it *does* mean that the person has had a tuberculous *infection* which, in the absence of any symptoms, has never attained the dignity of tuberculous *disease*. As proof of this, about 65 per cent of all adults will react positively to the skin test, yet the vast majority will be in a perfect state of health. After the skin test has been made on members of the sick individual's family, all those reacting *positively* (especially the children), should be x-rayed and the films interpreted by some competent physician or radiologist. Those showing definite or suspicious x-ray findings should be under the supervision of some doctor or clinic, and should be followed up by periodic x-rays for a term of years. It is here that the social worker comes into the picture, for it is by her efforts alone that

the follow-up system can be made to work, just as it is by her untiring energy that the members of the family of the active case, diagnosed in the clinic, can be forced to present themselves for skin-testing and possible subsequent x-raying. It is part of the private practitioner's duty to see that all members of the patient's family are tuberculin tested.

In a broadcast of ten minutes' duration, only the high spots of tuberculosis prevention can be touched. The way is long and hard—one meets ignorance, prejudice, hostility, resentment, sympathy and cooperation. In these United States, forty-eight state tuberculosis associations and forty-eight state boards of health are on their way, are working hard, are headed in the right direction; and, eventually, will put their heels on the neck of the reptile, tuberculosis. They can all be incredibly aided by thoughtful and earnest assistance on the part of those they are trying to serve and to save, the people of their respective commonwealths.

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Marital Tuberculosis

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THE PHYSICIAN is called upon to solve for the tuberculous patient many problems of marriage. Next to the effect of pregnancy on the tuberculous patient and the danger of infecting the offspring, the most common question is the danger of transmitting the disease to the healthy consort. In view of our changing concept of the pathogenesis of tuberculosis, it is important to analyze the subject of marital tuberculosis in the light of recent evidence.

There has been considerable difference of opinion regarding conjugal phthisis. Fishberg is strongly of the opinion that tuberculosis in both husband and wife is rare in spite of the intimacy of the contact. Of 170 couples in which one of the consorts was tuberculous, it was found that only 2.5 percent were phthisical. Pope and Pearson have made statistical studies of this problem in England,

and have come to the conclusion that the chance of tuberculosis occurring in both husband and wife is small,—about the same as the incidence of insanity in both husband and wife. There are many who contend that, when marital tuberculosis does occur, it is characterized by a favorable course of the disease in the secondary cases; and that soon after the actively disease partner is removed the infected consort recovers his or her health. The further claim is made that only rarely is progressive tuberculosis observed in the newly infected consort. It is their conviction that phthisis can develop only in those adults constitutionally predisposed to the disease, regardless of the opportunities for contact and reinfection. They base their concept on the theory that the unaffected consort has in all probability been infected during childhood and that the resulting immunity makes reinfection unlikely. All the authors referred to above tend to minimize the significance of latent and even active quiescent phthisis in the consort.

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The excellent statistical work of Opie and McPhedran tends to refute these claims. In 21 cases of tuberculosis in husband or wife, three revealed active disease in the consort, and seven latent tuberculosis. Thus in 10 of these 21 families, manifest or latent tuberculosis developed. They consequently conclude that one-half of the partners of tuberculous consorts will be infected after marriage. They found this to be more than ten times the normal incidence in the community. Ward studied 156 husbands and wives of tuberculous patients in England. He found 58 per cent to be tuberculous, whereas only 20 per cent of extra-marital contacts were tuberculous. He concluded that direct exogenous infection is the important factor in the spread of tuberculosis; and the greater and more frequent the exposure, the greater the chance for active tuberculosis to develop. Verco, in a statistical review of marital tuberculosis in Australia, noted that of 254 husbands dead of phthisis, 40.5 per cent of the wives died of tuberculosis. However, of the widowers of 264 wives dead of phthisis, only 11.7 per cent died of phthisis. He concludes, therefore, that women are three to four times as liable to develop marital tuberculosis as are men. Others have substantiated the claim that conjugal tuberculosis is more common in women.

Arnould reported 53,069 couples in France of which either the husband or the wife suffered from tuberculosis; here, conjugal tuberculosis was found in 8.4 per cent. He concluded that there was a definite increase of tuberculosis as a result of marital contact. However, the incidence of marital phthisis did not exceed the morbidity of the general population by more than 50 per cent. H. L. Barnes reported 150 cases of marital tuberculosis in the state of Rhode Island. He based his statistics on tuberculous patients whose consorts had died of phthisis. This eliminated the error of false clinical diagnoses. He found the percentage of phthisical patients widowed by tuberculosis to be over three times as great as the average for the married people of the community. The average period intervening between the death of the tuberculous consort and the discovery of tuberculosis in husband or wife was 4.5 years. This supports the concept that when tuberculosis is transmitted by

a married partner, it should not be expected to be evident in a few days or weeks. The recently infected consort may not develop recognizable disease for several years. This gives increased significance to the large number of latent lesions discovered by Opie and McPhedran in the consorts of tuberculous couples, and suggests the advisability of a closer follow-up of these inactive lesions.

Those who minimize the dangers of conjugal infection emphasize the immunity conferred by childhood infection. As immunity to tuberculosis is at times short-lived and unstable and is influenced by many social, economic, metabolic and unknown factors, one must look for more convincing evidence that permanent immunity against tuberculosis is conferred by childhood infection. In many communities in this country, some 50 per cent of the young adults reach marriageable age uninfected, as manifested by a negative tuberculin test. No one as yet has studied a group of these tuberculin-negative individuals throughout a period of marriage with a tuberculous consort to determine whether the lack of the alleged immunizing influence of childhood infection is important. Latent tuberculosis must not be ignored or minimized. These latent lesions are usually limited to a small part of the apex and are easily overlooked on the x-ray film or dismissed as of no significance. The younger the adult, the more significant are these strand-like infiltrations of the apex; and the greater the chance for them to develop into active disease. There is no means of determining how long the disease has remained latent before it becomes manifest. There is good reason to believe that it frequently takes many years.

Little is known concerning the conditions under which latent apical lesions assume the character of manifest disease. Surveys among healthy adolescents and young adults over a period of several years reveal that a large number (over 20 per cent) of individuals showing latent apical tuberculosis become ill with active disease. It may be accepted as an axiom that manifest tuberculosis casts its shadow ahead of it in the form of latent apical tuberculosis. To ignore this asymptomatic period of the disease frequently results in extensive consolidation and cavitation by the time symptoms arise. Experience has

shown that latent or subactive lesions respond readily to therapy. In a recent survey by Hetherington, Israel and Kreitz among students of a teachers' college in Pennsylvania, it was found that approximately one-third of those who revealed significant latent apical infiltrations by x-ray developed active tuberculosis within three to six years. These were young adults who were not being exposed to the additional hazard of constant contact to tuberculosis, such as occurs in consorts of tuberculous patients. The statistical work of Opie among contacts exposed to tuberculosis after the age of 15, for a period of 10 to 14 years, revealed active disease developing in 10 per cent. From these studies it may

be concluded that adults are not immune to exogenous infection.

The preponderance of evidence indicates that marital tuberculosis is a definite hazard for the consort of the tuberculous patient. The physician will be contributing much toward the detection of early tuberculosis if he will follow with annual or semi-annual roentgenograms any chest film of an apparently healthy consort of a tuberculous patient which shows fine strands or mottling of an apex. Comparative x-ray films revealing slight widening, softening or extension of these apical shadows should be regarded as a danger-signal and treatment strongly advised.

Discussion of the Activities of the Committee on Tuberculosis among Negroes

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THE COMMITTEE on Tuberculosis Among Negroes has been in existence for seven years. Two years ago, or at the end of a five-year period, a detailed report of its activities was published and has been rather widely distributed. This report was summarized in a paper presented at the annual meeting of the National Tuberculosis Association in Milwaukee in 1937. Any discussion of the committee's work at the present time will necessitate some repetition.

The disparity in the white and colored tuberculosis mortality rates is so great that the need for special emphasis on this phase of Negro health is evident. In October, 1930, the Surgeon General of the United States called a conference for the purpose of discussing the problem. It was decided at that time that further investigation should be made under the auspices of the National Tuberculosis Association and, as a result, the Committee on Tuberculosis Among Negroes came into existence. The Julius Rosenwald Fund made available to the National Association certain funds to be expended over a five-year period in studying the Negro tuberculosis problem. The Rosenwald Fund has recently subsidized the study for an additional period of five

years. The active work has been done by Dr. C. St. C. Guild, acting in the capacity of Field Secretary. To date, much of his time has been spent stimulating interest in the problem of tuberculosis among Negroes on the part of state and local tuberculosis associations, health departments, the medical profession and the general public. He has investigated current administrative practices in the control of tuberculosis among Negroes in all states and cities with large colored populations, and has attempted to secure wider utilization of such procedures as seemed most efficient.

Because of the complexity of the problem, it was deemed advisable to make an arbitrary break-up of the Negro population into three major groups; namely, the Southern Rural, including smaller towns and cities, the Northern Urban, and the Southern Urban. The need for such a division is obvious. The procedures applicable in the North may not be feasible in the South, and even the same techniques cannot be applied to all urban and rural districts. In general, a program for control of tuberculosis among Negroes is essentially the same as for any other group or unit of population. It must, however, be adapted to the peculiar problems involved. These problems

are largely economic and educational. The Negro constitutes approximately 10 per cent of the population of the United States. Tuberculosis, which now ranks seventh in importance as the cause of death among whites, ranks second among the colored population. In fact, tuberculosis mortality among the colored population now stands at the level where the white mortality hovered twenty-five years ago. Obviously, the measures which have reduced tuberculosis in the general population from first to seventh have, to a certain degree, failed in the colored race.

The lack of specific methods of immunization and treatment for tuberculosis has made it necessary to try various types of control procedures. Some of these have been successful, while others have proven of little value. Out of this system of trial with success or failure, the more effective practices have been retained in our present-day measures. Success can best be determined by the declining death rate and decreased incidence of the disease. If we use general mortality figures as an index, we have attained considerable success, but as the death rate from the disease declines, continued reduction becomes more difficult. Concentration of effort, therefore, becomes desirable in those groups where the rates are out of proportion to the general figures. When one-tenth of our population provides nearly 30 per cent of our annual tuberculosis deaths, we are confronted with a situation which challenges our methods of public health effort. The tubercle bacillus draws no color line, and it is futile to expect to control tuberculosis in the community until all foci of infection receive equal attention and correction.

The Negro's increased susceptibility to tuberculous infection has been advanced as a reason for his high mortality. A great deal has been written on the subject and there is some evidence to indicate that he has a racial handicap. Any lack of inherited immunity, however, is a condition beyond our control. In fact, the existence of an increased susceptibility should stimulate us to find better ways and means of providing protection from infection. The problem, however, is far broader than any genotypic difference, which after all is only academic in its application. The crux of the situation would seem to rest in

the matter of adequate medical care, health education and economic improvement. We cannot hope for much change in the health status of the Negro until he receives a fair amount of service, and the allocation of such service must be on the basis of his unit need and not based on the unit of population. In order to accomplish this, there must be more accurate statistics and tabulation of health activities by color.

The need for a greater number of beds for the isolation and treatment of tuberculous patients does not require discussion before this group. Comparatively few states have as yet been able to meet the recognized standards of good public health practice, and no doubt the Negro has suffered a great deal from the lack of hospital facilities available for his care. Home conditions are usually inadequate, because of overcrowding and the lack of proper food. The dearth of knowledge of those things which are essential for recovery and for the protection of other members of the family is a decided handicap. We must look to our state, county and municipal authorities for correction of the hospital situation, and improvement will come largely through the influence exerted by public opinion.

There is a need for the right kind of Negro leadership in planning and carrying on a tuberculosis program. We have been impressed, in our work in Pittsburgh, with the help which has been received from the Negroes themselves and with their desire to assume as much responsibility as possible for the care of their own people. Our Negro death rate is four times as high as that of the white population. Yet, until eight years ago, comparatively few Negroes attended the tuberculosis clinics and a very few patients were admitted to the various sanatoria. Something was needed to stimulate their interest in health and to promote a program which would more adequately meet their needs. A conference with Negro leaders resulted in plans for a survey of Negro health conditions in the city. The study included complete medical examination of over 8,000 Negroes, selected so as to obtain a fair cross-section of the 55,000 Negro population. At the same time, an intensive program of health education was begun, and opportunity was given to Negro

physicians to receive training in the diagnosis and treatment of tuberculosis. The active work of the survey continued over a period of four years, with the result that the Negro population became very much tuberculosis-conscious. Three physicians, who showed exceptional aptitude and interest, were provided with dispensary facilities and have continued to operate their own clinic in a most satisfactory manner. The annual attendance now exceeds three thousand visits, and there has been a consistent increase in clinic attendance. These men have complete charge of clinic examinations, do their own pneumothorax work, and make their own x-ray interpretations. Admissions to sanatoria have steadily increased, and additional hospital beds will soon be available for Negro patients. We hope, in the near future, to have a hospital service sufficiently large to justify the employment of Negro residents and Negro nurses. We are convinced that the use of Negro physicians and nurses has stimulated an interest in health problems among their own people which could not have been obtained in any other way.

The establishment of Health Institutes in the South has been a big step forward in providing opportunity for Negro physicians to receive medical training. Several of these institutes have been sponsored by tuberculosis societies with most gratifying results. This year, one of the physicians on my staff was invited to participate in the Texas and South Carolina Meetings. He returned with a most enthusiastic report of the plan, and was particularly impressed with the desire of the physicians in attendance to take advantage of this educational opportunity. This type of institute should be developed in as many localities as possible in order to reach a larger group of physicians. The courses might well be broadened in their scope to cover other subjects vital to public health needs. What has been said about the training of Negro physicians is equally true for the training of public health nurses. The Negro public health nurse is the most effective agent in giving information on health to her people. She is equipped to supply instruction and home supervision. Her special skill as a teacher of health and the ease with which she gains the confidence of families because of her care

of the sick make her a valuable worker in the field of tuberculosis control. Effective home supervision of cases must be regular and in some instances sustained for many years. Newly discovered families in which there is tuberculosis require months of intensive teaching, so that the hygiene of tuberculosis may become an established habit. The patient himself needs guidance for years, if his returning health is not to be jeopardized. The properly trained Negro public health nurse has demonstrated her ability to work more effectively among her own people than the white nurse, and she should be given every opportunity to prepare herself for this important piece of work.

The subject of health education is a broad one, and its effective application to the Negro population is of great importance. We must bear in mind that a large percentage of the group we aim to reach are not equipped to benefit from the usual methods of teaching. This applies not only to the Negroes of the rural South, but to those living in the urban centers of the North. It was Professor V. A. Edwards, of Moorehouse College in Atlanta, who said: "There is a need for the story of health to be told in the language and terms of the people whom it is designed to help." Ways and means of advancing health education among the Negroes has been one of the difficult problems of the Committee. A start has been made, but just how successful it will be, only the future can tell. The work to date has been through the distribution of specially prepared health publications, utilization of Negro newspapers, the development of better student health services in the Negro colleges, promotion of essay contests and the use of motion pictures. You are familiar with the pamphlet entitled *How You Get T. B.* This pamphlet was prepared at the Committee's request for use in the less privileged groups of Southern Negroes. It was presented first with some misgiving, but its acceptance has been a source of a great deal of satisfaction. More than 200,000 copies have already been printed and used both in the North and in the South. Some changes, particularly in the illustrations, now seem desirable, and in all probability it will be re-written in the near future. The essay contest several years ago, started as an experiment in the Negro col-

leges, has met with such success that it has been continued each year and extended to high school students. From a small beginning, this educational feature grew, until last year 50,000 essays were submitted. It is estimated that the number this year may reach the 100,000 mark. The educational value of the contest is apparent. The mere fact that each participant must familiarize himself with the tuberculosis problem makes him a potential educator in his family and among his associates. The splendid work of Dr. Cornelly in promoting better student health services in Negro colleges needs no more than mention at this time. This year for the first time the National Tuberculosis Association has prepared an educational motion picture especially for Negro groups. The cast is all Negro, and while the film was designed primarily for Negro audiences, other groups will enjoy it because of the pleasure derived from listening to the world-famous Tuskegee Choir, and the fact that the scientific truths apply to white people as well as to Negroes.

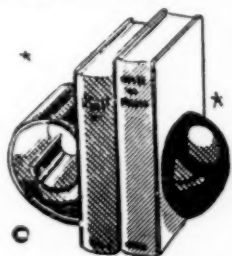
While the subject of syphilis is somewhat outside the province of a tuberculosis committee, the high incidence of the disease in tuberculous Negroes called attention to a possible relationship between the two infections. There is a dearth of knowledge concerning methods of treatment when the two conditions exist in the same patient. Some confusion also exists as to proper interpretation of serological reactions. We have been for-

tunate in having the co-operation of a group of syphilologists associated with the United States Public Health Service who, with the superintendents of several tuberculosis sanatoria, are now carrying out a series of studies on the possible significance of the co-existence of the two diseases. It is hoped that some additional light will be thrown on the subject from the standpoint of interpretation of serological reactions and uniform procedures for treatment.

In conclusion, we can briefly summarize the Negro tuberculosis problem as follows:

1. There is a need for continued concentrated effort if this reservoir of infection is going to be brought under control.
2. The right kind of Negro leadership is desirable. Negroes should have a part, both in the planning and carrying out of any program which involves their welfare.
3. Equal opportunities for health protection through the provision of better environment, and education in the laws of healthful living should be made possible.
4. Greater hospital and dispensary facilities, with more Negroes trained in the diagnosis and treatment of tuberculosis, are needed.
5. Adequate home supervision by properly qualified public health nurses is essential.
6. Given these necessities in full measure, the Negro tuberculosis mortality figures should more nearly conform to those of the white population.

BOOK REVIEW



"YOUR CHEST SHOULD BE FLAT."

S. A. Weisman M.D., F.A.C.P.

J. B. Lippincott Company, Philadelphia, 1938.

This little book is the report of a painstaking piece of work by the author. As the title implies, the content is the proof of that title. The conclusion reached by Dr. Weisman is that the chest with greater lateral diameter compared with its anterior-posterior diameter (the flat chest) is "healthier" than the chest with a comparatively greater anterior-posterior diameter (the deep chest).

He supports this thesis very well by an impressive number of measurements of chests and a correlation of these measurements with various other factors thought to be indicative of health and disease including the prevalence of tuberculosis in the various degrees of chest "flatness".

The author's interest in chest shape and its relation to disease is mainly in respect to the question of susceptibility to tuberculosis. Apparently the deep chested person is more susceptible to that disease. That being true he ought to be more carefully guarded against exposure and more regularly checked for infection.

In various statistical studies he found reason to conclude that poor childhood environment contributed largely to the formation of the undesirable deep chest type.

The book is concluded with general recommendations in respect to prevention of deep chest and of tuberculosis. No panacea is claimed. It merely aims to present one more factor that may be helpful in minimizing the number of new cases of tuberculosis.

I. M. E.

The Integration of the Teaching of Preventive and Clinical Medicine*

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ALTHOUGH remarkable progress has been made in enlarging the facilities and in improving the methods of teaching the clinical branches in the medical curriculum, there has not been a comparable advance in providing facilities for teaching the preventive and public health aspects of medicine. This statement has been made so often that it has become commonplace, and yet I wish to call attention to the fact that this deficiency in medical education is proving unfortunate because (1) there is unusual interest on the part of the public in the prevention of disease and in health activities (2) the practitioner of medicine should make a much larger contribution in applying the knowledge which is now available in the control of preventable disease and in the protection of individual and community health; (3) there is urgent need for physicians trained in public health to fill positions in official and non-official health agencies; and (4) there is an increased demand for graduates of medicine who are prepared to teach and carry on research in the field of public health. These observations emphasize the immediate necessity of affording better facilities for undergraduate medical students to acquire the newer knowledge in preventive medicine and public health. Unless this is done, future practitioners of medicine cannot take adequately their places in the rapidly expanding national health program.

Obviously, conditions within and particularly surrounding medical schools vary greatly, and therefore, no plan or system can be applied uniformly to the instruction of undergraduate students; nor is there any easy approach which will facilitate instruction in this phase of medical service. Results can only be attained by constant attention to details

by the teaching staff concerning any plan which may be developed; and methods of instruction must be employed which will gain the interest and maintain the respect of the students.

An important objective in any plan of teaching undergraduate medical students is to integrate the teaching of preventive and clinical medicine. It is my judgment that this cannot be accomplished successfully by placing the responsibility on the medical faculty as a whole; neither can it be obtained by sporadic effort or fragmentary instruction; but procedures should be employed which will afford the student an experience comparable to that gained in well organized courses of anatomy, pathology, physiology, surgery, pediatrics and other subjects of the curriculum.

Much factual information in the field of public health and prevention of disease is available now, the application of which will prove invaluable in the practice of medicine. This information must be organized and presented to the student so that he not only can acquire techniques which should be employed but he should be imbued with his responsibility in the practice of preventive as well as curative medicine. It seems logical, therefore, to accentuate the thesis that medical schools should have full-time departments of preventive medicine and public health with reasonably adequate budgets and with facilities for giving systematic instruction to undergraduate students as an essential part of the curriculum. If this is not done, it would seem to preclude the possibility of a large proportion of graduates of medicine becoming competent to practice preventive measures and to cooperate effectively in the state and local health programs.

The general medical faculty can make a contribution also by imbuing the student with his responsibility as a future practitioner in the application of preventive measures. All clinical courses can make some contribution in the instruction of students concerning the practice of the public health aspects of medi-

* Read at the Forty-ninth Annual Meeting of the Association of American Medical Colleges, held in Syracuse, N. Y., Oct. 24-26, 1938. Reprinted from Jan. issue, 1939, of the Journal of the Association of American Medical Colleges.

** Dean and Professor of Preventive Medicine and Public Health, Vanderbilt University School of Medicine.

cine. Students gain experience in antepartum and postpartum care in the outpatient clinic of every well conducted teaching hospital. Immunization procedures should be and usually are practiced in the pediatric clinic. The subject of nutrition is emphasized in the courses in physiology and biochemistry and the application of this knowledge is taught thoroughly in clinical medicine. The contact of the student with patients at the bedside and in the outpatient clinic affords opportunity to get some knowledge of dietetics. His experience in surgery should give him a sense of responsibility concerning the value of early diagnosis, methods of treatment and the prevention of cancer. The measures that may be employed in the prolongation of life and in the reduction of mortality from heart disease, as well as their limitations may be acquired in clinical medicine. Likewise, the diagnosis and treatment of tuberculosis and the value of case finding procedures can be emphasized in medical and pediatric clinics. It is through and by these measures that closer affiliation or actual integration can be established by practitioners in a community with the program of the state and full-time local health organizations.

Dramatic consideration has been given within recent months to a national program for the prevention and control of syphilis. This widespread disease generally has been diagnosed poorly and treated inadequately. We know the technique and skill required for the arrest and cure of the majority of those persons who have latent and active forms of this disease, but there is great need for a more intensive clinical experience and a knowledge of epidemiologic methods necessary in the location of cases and contacts, and in general follow-up procedure to bring under treatment persons infected with syphilis. The epidemiologic approach requires a peculiar technique, if results are to be secured, and much blundering by those who are inadequately trained may be the outcome. Unless the diagnosis and treatment of syphilis, particularly in the syphilis clinic used for teaching, are coordinated with epidemiologic field investigations, results cannot be obtained commensurate with the expenditure incurred. Therefore, undergraduate medical students should not only be given clinical instruction, but

they should also have some knowledge of epidemiologic principles and their application in a case finding program and their significance in the control of this disease. It will prove of tremendous value if the medical profession is mobilized in a national program for the suppression of this plague and, therefore, future graduates of medicine should be imbued with the responsibility which they should assume in a syphilis control program.

Well organized and well administered local, county and municipal health departments can be used for giving the students some knowledge of the practical aspects of public health. This avenue may afford an experience which is analogous to the "clinical clerkship," broadly speaking, in medicine. Some years ago, under the direction of Dr. John B. Grant of the International Health Division of the Rockefeller Foundation, clinical clerkships in public health were a part of his program in teaching public health in the Peiping Union Medical College. Every student was required to spend four weeks working in a field area of the city health department, and following this experience he could devote an additional three weeks to some special phase of public health. The student gave all his time to this work during this period and worked under supervision. The students may be required, also, to make careful sanitary surveys of the health department of a small city as a means of gaining experience in the plan of organization and in the techniques of public health. This method of instruction was used first by Dr. M. J. Rosenau at Harvard University for a number of years. Field demonstrations, in an efficiently administered full-time rural county or district health department, carefully planned and conducted, and special field studies can be used effectively in introducing the student to the principles and operative procedures in the practice of preventive medicine and public health.

There was established at Harvard University several years ago by Dr. David L. Edsall a series of "clinics in public health," which I presume are being continued. I believe there were twenty-one of these clinics, conducted by men who were especially competent to deal with the particular subject presented. These clinics were set apart to emphasize the integration of preventive and curative proce-

dures in practice. This objective may be attained also by holding a limited number of clinics, as is done at Vanderbilt, in cooperation with the department of medicine by having a representative of the department of preventive medicine and public health participate. This has the advantage of not being a set clinic in public health because it is done by invitation from the department of medicine to have a "combined or joint clinic." These clinics have been held cooperatively on typhoid fever, undulant fever, malaria, lead poisoning, and other subjects. They can be made very instructive, particularly if the clinical clerk in advance investigates the causative factors or background of the disease as a part of the clinical record which he is requested to present after the patient's case has been discussed by the professor of medicine, with reference to diagnosis, symptoms, pathology, prognosis and treatment. The clinical clerk, in discussing his field investigations, may use stereopticon slides to illustrate his findings. This is followed by comments by a representative of the department of preventive medicine and public health. The presentation of these facts is, necessarily, brief but impressive. These clinics may be of much interest as a means of correlation between the activities of the two departments and afford opportunity to present a well rounded discussion acquainting the students with the background or causative factors of the disease which has caused the patient to seek admission to the hospital.

Other ways may be used to integrate the teaching of preventive and clinical medicine. We have at Vanderbilt a laboratory course in parasitic diseases, not parasitology from a zoological standpoint, which considers the prevalence, distribution, mode of infection, symptoms, treatment and measures for the control of these communicable diseases. This phase of teaching emphasizes diagnostic methods with reference not only to clinical medicine but to public health in epidemiological investigations. This course is given during the third trimester of the second year and serves as one of the introductory courses preliminary to entering on a more intensive study of clinical medicine in the third curricular year.

A cooperative arrangement may be developed also between the departments of bac-

teriology and public health. For a number of years we have given a limited number of lectures, correlated with the laboratory work in bacteriology, in the application of epidemiological principles in the control of certain infectious diseases. These discussions are given following the laboratory work on groups of infectious organisms, such as the gram-negative and gram-positive cocci, colon-typhoid-dysentery group of organisms, respiratory infections, spirochetal infections, and some emphasis is given to personal hygiene and the broader aspects of public health. Only about eight of these lectures are given in our course. These discussions are held during the first trimester to second year students. We believe this arrangement has strengthened the teaching in both departments.

A member or members of the department of preventive medicine may attend ward rounds with the professional staff in clinical medicine with reasonable frequency. This affords an avenue for participation in the discussion of cases which involve public health problems. Thus, the house staff, as well as members of the professional staff in medicine, become interested and may be stimulated to cooperate in their own teaching concerning the preventive phases of medicine. We have for several years found it also worth while to assign a representative of our department to the Outpatient Clinic three mornings during the week to participate in the examination of patients and to serve as a consultant in preventive medicine.

There are also research problems which may be developed more successfully on a cooperative basis between two or more departments, and members of the department of preventive medicine may participate. We have availed ourselves of joint research projects with the departments of anatomy, pharmacology, clinical medicine, pediatrics and pathology in the School of Medicine, with the department of sociology in the College of Arts and Science, and with the State Department of Public Health. This correlation increases one's efficiency in teaching and serves to impress the students with the productive value of the integration of preventive and clinical medicine, or also with the basic medical sciences.

At times there are problems which confront

individual members of the clinical staff, and cooperative relations may be established which afford opportunity for the department of preventive medicine to make contributions in the solution of them. In other words, the department should serve as a source of information, or, so to speak, a "clearing house" especially for clinical departments, as an aid in the solution of problems which involve the consideration of the preventive aspects of medicine.

The spirit and attitude of medical students concerning the department of preventive medicine and public health will depend largely on informal contacts which they have with those who are primarily responsible for this phase of instruction. This may be facilitated by conferences concerning discussions which are prepared for seminars, and also environmental case studies. The assignment of papers in journals to abstract, dealing with various subjects in public health, requires additional conferences with some member of the teaching personnel in preventive medicine, which should prove stimulating and informative to the student. This may be done by having a list of well selected papers distributed to members of the class and requiring each student to abstract two or more papers each month throughout the regular course in preventive medicine and hygiene. This is facilitated by providing the student

with an outline which is suggestive in the preparation of the abstract. This develops orderly reading and habits of logical expression, and causes the student to seek information from original sources and current literature.

I have endeavored to recount, briefly, some observations and methods concerning instruction in public health, as a result of studies and experiences in dealing with this phase of medical education. It has been my purpose to show that any attempt to instruct undergraduate students in the preventive and public health aspects of medicine requires a full-time teaching personnel which can devise ways and means for enlisting and maintaining the interest of the student. Many procedures may be employed which, if followed up carefully, will be valuable in the integration of preventive and clinical medicine. The favorable attitude and influence of the faculty is of tremendous importance in imbuing the student with his responsibility in the application of preventive measures. An understanding of the administrative procedures and techniques of preventive medicine and public health should cause the future practitioner to cooperate more uniformly with the state and local health organizations by participation in the public health program. This will result in raising the level of achievement in the practice of clinical as well as preventive medicine and community health.



GOVERNOR FOR THE PHILIPPINE ISLANDS REPORTS

Dr. Miquel Canizares, Manila, Governor of the American College of Chest Physicians for the Philippine Islands reports that the Quezon Institute, formerly the Santol Tuberculosis Sanatorium, is undergoing extensive alterations. When the new pavilions are completed there will be accommodations at the sanatorium for about 800 patients. A planigraph is in use at the institution. For 1937, 38,075 fluoroscopic examinations and 1,307 skiagrams were performed by the x-ray department. The surgical department is equipped for thoracoplasty, apicolysis, with or without plombage, and closed intrapleural pneumolysis. Artificial pneumothorax was given to 1,360 patients. There were 37,463 refills given during that year. Twenty five patients were given phrenicectomy

and 114 intrapleural pneumolysis operations were performed.

Nine Bureau of Health physicians have been trained at the institution, and there are twelve physicians under training at the present time. The training period is for two years. Eleven anti-tuberculosis dispensaries and two other provincial sanatoria are maintained. These projects are sponsored by the Philippine Tuberculosis Society in conjunction with the Bureau of Health.

A travelling x-ray unit of the Bureau of Health has performed more than 276,500 fluoroscopic examinations of the masses during the past five years. Plans are underway to increase these ambulant x-ray units to at least ten.

A New and Practical Position for Aspirating Thoracic Cavities

S. C. DAVIS, M.D., F.A.C.P. and REDFORD A. WILSON, M.D., F.A.C.P.*
Tucson, Arizona

ASPIRATING fluid from a thoracic cavity with the patient in a sitting position is often very uncomfortable to the patient, fainting not being uncommon. Too frequently the needle is not at the bottom of the cavity and fluid remains. With the patient recumbent, a more comfortable position is usually obtained; syncope is unlikely, and the needle is in the most dependent portion of the cavity, which is, therefore, emptied of fluid.

The equipment is simple, the procedure is easier than it is with the patient in a sitting position. Any flat table may be used; a wheel-stretcher suffices admirably. Two boards ten inches wide, one inch thick, and a foot longer than the width of a wheel-stretcher are equipped with an iron band which hooks over

and around the edge of the stretcher, pillows are fastened on the ends which extend beyond the edge of the stretcher as shown in Figure I.

The needle is introduced in mid-axillary line; any interspace may be selected, because when the patient is on his side the needle is in the most dependent area. After introduction of the needle, the patient rolls over slowly on his side as shown in Figure II. This illustration shows the boards and the Gurney pad in place, the patient reclining, rolled on his side, and the needle in place for the aspiration. An attendant on the opposite side steadies the patient and the Gurney as he rolls over, for he is practically off the Gurney and on the boards when in position to aspirate. In this position nothing interferes with the operator or the needle and complete aspiration is accomplished with ease.

* Thomas-Davis Clinic, Tucson, Arizona.

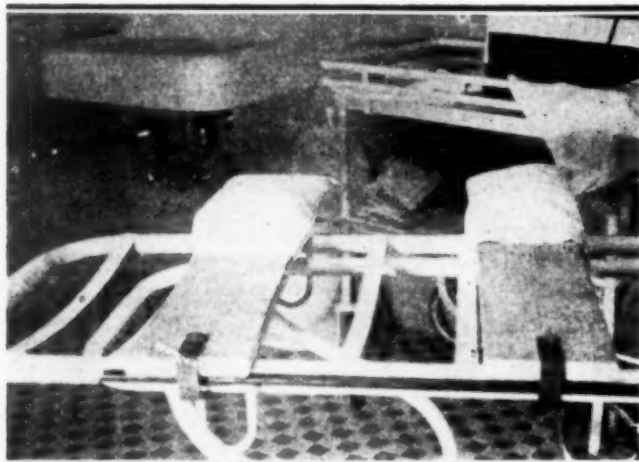


Fig. I.



Fig. II.

♦♦♦♦♦

AMERICAN PUBLIC HEALTH ASSOCIATION RECOMMENDS

The American Public Health Association has recommended to the Technical Committee on Medical Care that a new Cabinet Post of Secretary of Health be established and that the State Health Departments be made responsible for all medical and health services.

The above recommendations were developed by a committee appointed to

confer with Miss Josephine Roche, Chairman of the Interdepartmental Committee to Coordinate Health and Welfare Activities.

The program calls for Federal and State financial aid in establishing the necessary services and expanding the present services.

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J. E. POTTENGER, M.D.	Asst. Medical Director and Chief of Laboratory
LEROY T. PETERSEN, M.D.	Asst. Physician and Roentgenologist
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E. W. HAYES, M.D., Medical Director

Organization News

President Elect of College Visits El Paso, Texas

Dr. Ralph C. Matson, Portland, Oregon, President Elect of the American College of Chest Physicians paid a visit to El Paso, Texas, January 24th.

A luncheon meeting was arranged for Dr. Matson at the Hilton Hotel and the meeting was attended by the Fellows of the College at El Paso. Officers of the El Paso County Medical Society were special guests of the chest physicians.

Dr. Matson spoke on the progress of the Pennsylvania Plan in Organized Medicine and he reported on the present status of Extrapleural Pneumothorax operations being performed by the thoracic surgeons in California.

Dr. R. B. Homan, Sr., Chairman of the Tuberculosis Committee of the Texas State Medical Society reported on the progress of the committee in organizing Tuberculosis Committees in the County Medical Societies of the State.

Dr. C. M. Hendricks spoke briefly on the history of the College, and Dr. James J. Gorman, President of the El Paso County Medical Society spoke on the Service that the College can Render to the Physician in the General Practice of Medicine.

Other Fellows of the College made brief talks. A dinner was given in honor of Dr. Matson at Juarez, Mexico, that evening. Dr. Orville E. Egbert, Governor of the College for the State of Texas presided at the luncheon meeting and with Dr. R. B. Homan, Jr., Secretary-Treasurer of the College, was in charge of the arrangements for Dr. Matson's reception.

Committee on Medical Schools

Dr. E. W. Hayes, Monrovia, California, Chairman of the Committee for the Study of Undergraduate Teaching in Medical Schools reports that a questionnaire has been prepared by the committee which will be submitted to the deans of all accredited medical schools in the United States. The committee will attempt to ascertain among other things, the methods employed in the teaching of chest diseases to the medical students. The committee will attempt to find out, whether the teaching of tuberculosis to medical students can be improved upon without the necessity of increasing time allocation; whether sanatoria and hospital facilities are made available to internes and students; as well as other information which is of particular concern to the American College of Chest Physicians.

The members of the Statistical Committee of the College and the Governors of the College will be called upon to assist the Committee for the

Study of Undergraduate Teaching in Medical Schools in compiling information. A preliminary report will be prepared by the committee and will be submitted at the annual meeting of the College at St. Louis, May 13-14.

After a careful study of existing conditions, it is the plan of the committee to submit a proposal to the Association of American Medical Colleges whereby minimal standards for the teaching of lung diseases can be put into effect in all of our medical schools.

Committee for the Study of Undergraduate Teaching in Medical Schools:

E. W. Hayes, M.D., Monrovia, Calif., *Chairman*,
John Alexander, M.D., Ann Arbor, Michigan,
Vice-Chairman.

A. J. Cohen, M.D., Philadelphia, Pennsylvania,
Benjamin Goldberg, M.D., Chicago, Illinois,
Jay Arthur Myers, M.D., Minneapolis, Minnesota,
John H. Peck, M.D., Oakdale, Iowa,
William Atmar Smith, M.D., Charleston, S. C.,
Sam'l H. Watson, M.D., Tucson, Arizona.

Georgia Tuberculosis Committee Outlines Program

Dr. Champ H. Holmes, Atlanta, Georgia, Chairman of the Tuberculosis Committee of the Georgia State Medical Society, submitted the following program to the members of the committee for study: "Some of the duties and activities of this committee are as follows: (1) To study and help promote in general the tuberculosis problem in the state. (2) To cooperate with the department of tuberculosis of the Board of Health in the control and treatment of tuberculosis, field surveys, and sanatorium care. (3) To encourage papers on tuberculosis for the annual meetings of the State Society and for the district medical meetings. (4) To encourage formation of tuberculosis committees in the country medical societies." The members of the committee are:

Dr. Champ H. Holmes, Atlanta, *Chairman*,

Dr. H. C. Atkinson, Macon; Dr. W. C. Cook, Columbus; Dr. W. H. Lewis, Rome; Dr. R. C. McGahee, Augusta; Dr. R. V. Martin, Savannah; Dr. H. C. Schenck, Atlanta; Dr. J. A. Simpson, Athens; Dr. E. F. Wahl, Thomasville; Dr. C. D. Welchel, Gainesville.

California Reports Tuberculosis Committee

The Medical Society of the State of California has appointed the following physicians on their recently organized Tuberculosis Committee:

Dr. William C. Voorsanger, San Francisco, *Chairman*; Dr. Chesley Bush, Livermore; Dr. Carl Howson, Los Angeles; Dr. Philip Pierson,

(Continued on Page 30)

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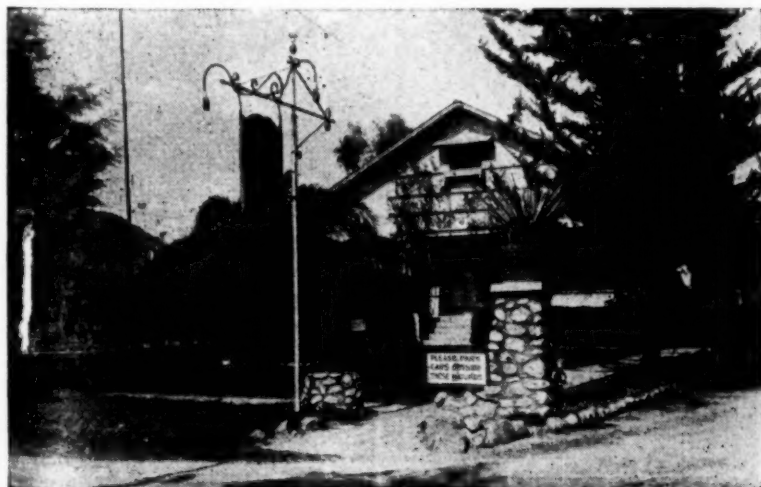
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C. E. ATKINSON, M.D.
MEDICAL DIRECTOR

San Francisco; Dr. Sidney Shipman, San Francisco.

Dr. Voorsanger, the Chairman of the Committee is the Governor of the American College of Chest Physicians for the State of California.

Texas Reports County Tuberculosis Committees

Dr. R. B. Homan, Sr., El Paso, Texas, Chairman of the Texas State Medical Society Tuberculosis Committee announces the following County Medical Societies have organized Tuberculosis Committees in keeping with the "Pennsylvania Plan."

Bexar County: Dr. Charles J. Koerth, Supt. W. O. W. Hospital, San Antonio; Dr. R. G. McCorkle, 1214 Nix Bldg., San Antonio; Dr. James L. Anderson, 1220 Medical Arts Bldg., San Antonio.

Hunt-Rockwall-Rains Counties: Dr. L. W. Seyler, Commerce, Texas; Dr. W. C. Morrow, Greenville, Texas; Dr. P. W. Pearson, Emory, Texas; Dr. J. L. Austin, Rockwall, Texas.

Jefferson County: Dr. Louis Knoepp, Beaumont, Texas, Chairman; Dr. A. R. Autrey, Port Arthur, Texas; Dr. D. A. Mann, Beaumont, Texas; Dr. J. C. Craiger, Beaumont, Texas.

Webb-Zapata-Jim Hogg Counties: Dr. J. T. Hallsell, Laredo, Texas; Dr. W. R. Powell, Laredo, Texas; Dr. F. M. Canseco, Laredo, Texas.

Jasper-Newton Counties: Dr. A. J. Richardson, Jasper, Texas; Dr. J. N. Slade, Jasper, Texas; Dr. W. R. Worthey, Call, Texas.

Galveston County: Dr. L. W. Schekels, Galveston, Texas, Chairman; Dr. Boyd Reading, Galveston; Dr. Francis A. Garbade, Galveston.

Austin County: Dr. V. Gordon, Sealy, Texas; Dr. W. T. Brown, Wallis, Texas; Dr. H. E. Roensch, Bellville, Texas.

El Paso County: Dr. A. D. Long, El Paso, Chairman; Dr. John Morrison, El Paso; Dr. Ralph H. Homan, El Paso.

McLennan County: Dr. H. U. Woolsey, Waco, Texas, Chairman; Dr. Paul Power, Waco, Texas; Dr. W. C. Bidelsbach, Waco, Texas.

Dallas County: Dr. H. Frank Carman, Dallas, Texas; Dr. E. Mendenhall, Dallas, Texas; Dr. Robt. R. Shaw, Dallas, Texas.

Morris County: Dr. E. Y. Anthony, Omaha, Texas, Chairman; Dr. D. J. Jenkins, Daingerfield, Texas; Dr. D. R. Baber, Daingerfield, Texas.

Hutchinson-Carson Counties: Dr. W. G. Stephens, Borger, Texas, Chairman; Dr. H. G. Wallace, Borger, Texas; Dr. M. M. Stephens, Borger, Texas.

Tarrant County: Dr. John Potts, Fort Worth, Texas, Chairman; Dr. Bert. C. Ball, Fort Worth, Texas; Dr. Sim Hulse, Fort Worth, Texas.

Gregg County: Dr. E. T. Hilton, Longview, Texas, Chairman; Dr. Seth Downs, Kilgore, Texas; Dr. G. G. McKeller, Longview, Texas; Dr. J. R. Barcus, Gladwater, Texas.

Henderson County: Dr. D. Price, Athens, Texas; Dr. J. K. Webster, Athens, Texas; Dr. A. C. Horton, Brownsboro, Texas.

Dr. Orville E. Egbert, El Paso, is the Governor of the American College of Chest Physicians for the State of Texas, and Dr. H. Frank Carman, Dallas, is the Regent for the District.

SOCIETY NEWS

Dr. Marr Bisaillon, Portland, Oregon, Governor of the American College of Chest Physicians for Oregon has been named Chairman of the Tuberculosis Committee for the Oregon State Medical Society. Dr. Bisaillon has also been elected President of the Portland Academy of Medicine for the year 1939.

A Round Table discussion of Chronic Bronchitis and Bronchiectasis was held on January 25th before the District of Columbia Medical Society. Dr. Wm. D. Tewksbury, Washington, D. C., a Fellow of the American College of Chest Physicians, was chairman of the meeting; and Dr. E. R. Fenton, Washington, D. C., a Fellow of the College, presented one of the papers.

Dr. M. A. Cunningham, a Fellow of the American College of Chest Physicians and formerly Medical Director of the Holy Cross Sanatorium, at Deming, New Mexico; has opened offices at the First National Bank Building, El Paso, Texas.

A third Tuberculosis Hospital is in the process of construction at the Medical Center, Portland, Oregon. The hospital will be operated as a department of the Medical School.

We have found, in certain cases, a persistent positive sputum following a collapse, either by pneumothorax or thoracoplasty. This is often caused by a tuberculous ulcer in a bronchus.

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